No. 80-1952

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IN THE

# Supreme Court of the United States

OCTOBER TERM, 1981

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BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, M.D., as Commissioner of the New York State Department of Health,
*Petitioners,*

v.

WILLIAM YARETSKY, RALPH CUEVAS and THE GRAY PANTHERS, NEW YORK CHAPTER, *Respondents,*

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,
*Intervenors-Respondents.*

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**On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit**

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## BRIEF FOR RESPONDENTS

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## QUESTIONS PRESENTED

1. Does the issue of whether there is state action in a nursing facility's discharge or transfer, without a hearing, of a Medicaid patient present a justiciable controversy where the named respondents were threatened with summary discharge or transfer by their facilities following the non-enforcement of Utilization Review Committee determinations to discharge or transfer them, and where the pleadings were amended by agreement of the parties to present the issue?

2. Does state action attach to a nursing facility's summary discharge or transfer of a Medicaid patient when New York State exercises direct and comprehensive control over the very conduct in question, the State maintains a unique mutually interdependent relationship with nursing facilities, and the facilities discharge important public functions?*

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*Respondents submit that this question subsumes the non-constitutional issue of whether patient hearing rights under federal and state law attach to facility discharges or transfers of Medicaid patients.

## TABLE OF CONTENTS


| | Page |
|---|---|
| QUESTIONS PRESENTED | i |
| STATEMENT OF THE CASE | 1 |
| STATUTORY AND REGULATORY SCHEME | 7 |
| SUMMARY OF ARGUMENT | 15 |
| ARGUMENT | 18 |
| POINTS: | |
| I. The Case Presents A Justiciable Controversy | 18 |
| II. State Action Attaches To A Nursing Facility's Discharge Or Transfer Of A Medicaid Patient | 21 |
| A. Nexus between State and nursing facility conduct | 23 |
| B. Symbiotic relationship between State and nursing facility and facility's exercise of public functions | 28 |
| III. A Medicaid Nursing Patient Has A Right Under Federal And State Law To A State Agency Hearing When The State Takes Action To Adjust His Benefit Level Based On A Facility's Patient Discharge Or Transfer To A Lower Level Of Care | 33 |
| CONCLUSION | 35 |

## TABLE OF AUTHORITIES

CASES: Page

*Burton* v. *Wilmington Parking Authority*, 365 U.S. 715 (1961) ..... 18, 28, 29, 30, 31, 32

*Crowell* v. *Bensen*, 285 U.S. 22 (1932) ..... 33

*Flagg Brothers, Inc.* v. *Brooks*, 436 U.S. 149 (1978) ..... 17 24, 25, 27

*Fuentes* v. *Shevin*, 407 U.S. 67 (1972) ..... 27

*Gladstone, Realtors* v. *Village of Bellwood*, 441 U.S. 91 (1979) ..... 16, 18

*Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974) . 17 24, 25, 29, 30

*Joy* v. *Daniels*, 479 F.2d 1236 (1 Cir. 1973) ..... 32

*Kane* v. *Perry*, 41 N.Y.2d 1051 (1977) ..... 34

*Lopez* v. *Henry Phipps Plaza South, Inc.*, 498 F.2d 937 (2 Cir. 1974) ..... 32

*McQueen* v. *Drucker*, 438 F.2d 781 (1 Cir. 1973) ..... 32

*Marsh* v. *Alabama*, 326 U.S. 501 (1946) ..... 30

*Matter of Lee* v. *Smith*, 43 N.Y.2d 453 (1977) ..... 30

*Memphis Light, Gas and Water Division* v. *Craft*, 436 U.S. 1 (1978) ..... 29

*Moose Lodge No. 107* v. *Irvis*, 407 U.S. 163 (1972) ..... 17 24, 25, 29

*North Georgia Finishing, Inc.* v. *Di-Chem, Inc.*, 419 U.S. 601 (1975) ..... 27

*O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980) ..... 26, 33

*Polk County* v. *Dodson*, 50 U.S.L.W. 4077 (December 14, 1981) ..... 17, 24, 25

*Public Utilities Commission* v. *Pollack*, 343 U.S. 451 (1952) 26

*Sniadach* v. *Family Finance Corp.*, 395 U.S. 337 (1969) .. 27

*Teitelbaum* v. *Sorenson*, Civ. No. 79-199 PHX WEC (D. Ariz, March 16, 1979) ..... 30

*Traux* v. *Raich*, 239 U.S. 33 (1915) ..... 16, 20

*Tucker* v. *Toia*, 43 N.Y.2d 1 (1977) ..... 30

*United States* v. *Rumely*, 345 U.S. 41 (1953) ..... 33

## Table of Authorities Continued

Page

*United States* v. *SCRAP*, 412 U.S. 669 (1973) ..... 19

*United States Parole Commission* v. *Geraghty*, 445 U.S. 388 (1981) ..... 16, 18, 21

*Yaretsky* v. *Blum*, 592 F.2d 65 (2 Cir. 1980) ..... 2, 31

FEDERAL CONSTITUTION:

Article III ..... 18, 21

Fourteenth Amendment ..... 4, 16, 23

FEDERAL STATUTES:

42 U.S.C. § 1395 et seq. ..... 8, 9

§ 1396 et seq. ..... 7, 9, 10, 11, 12, 13

FEDERAL REGULATIONS:

42 C.F.R. § 405.120 et seq. ..... 23

§ 405.1120 et seq. ..... 11, 23

§ 405.1130 et seq. ..... 9, 11, 32

§ 420.100 et seq. ..... 11

§ 431.10 et seq. ..... 11, 12

§ 431.200 et seq. ..... 15, 34

§ 435.400 et seq. ..... 12

§ 435.900 et seq. ..... 12, 15

§ 440.40 et seq. ..... 23

§ 440.200 et seq. ..... 11

§ 442.1 et seq. ..... 11

§ 442.200 et seq. ..... 11, 13, 23

§ 442.300 et seq. ..... 8, 9, 11, 13, 23

§ 447 ..... 13

§ 456.200 et seq. ..... 8, 12

§ 456.300 et seq. ..... 8, 12, 32

§ 456.400 ..... 9

§ 456.600 et seq. ..... 10

## Table of Authorities Continued


Page

FEDERAL RULES:

Federal Medical Assistance Manual, § 5-60-20 . 8, 9, 10, 12, 23
§ 5-100-20 ..... 15
§ 60-90-20 ..... 11

STATE CONSTITUTION:

Article 17 §§1 and 3 ..... 30

STATE STATUTES:

New York Public Health Law § 2800 et seq. ..... 11, 14, 23
New York Social Services Law, § 22 ..... 15
§ 65 ..... 12
§ 364 ..... 11
§ 366 ..... 12
§ 367 ..... 11, 12

STATE REGULATIONS:

10 N.Y.C.R.R. § 414 ..... 11, 12, 23
§ 415 ..... 8, 9, 12
§ 416 ..... 8, 9
§ 420 ..... 8, 9
§ 421 ..... 8, 9
§ 704 ..... 9
§ 730 ..... 8, 9, 12, 15, 23
§ 731 ..... 8, 9, 12
§ 740 ..... 8, 9, 12, 23
§ 741 ..... 8, 9, 12
§ 742 ..... 11
18 N.Y.C.R.R. § 351 ..... 13, 15
§ 355 ..... 15
§ 358 ..... 13, 15, 34
§ 360 ..... 12, 15

**Table of Authorities Continued**

Page

§ 505 ..... 9, 10, 11, 12
§ 515 ..... 11
§ 516 ..... 11
§ 540 ..... 11, 12

STATE RULES:

New York State Department of Health:
Health Facilities Memorandum 79-23 ..... 12
79-47 ..... 9
80-54 ..... 10

New York State Department of Health:
Hospital Memorandum 76-135 ..... 12
77-9 ..... 10, 23
77-10 ..... 10, 12, 23
77-13 ..... 10, 23
77-35 ..... 12
77-60 ..... 10, 12
77-74 ..... 9, 10, 12

New York State Department of Social Services Administrative Directive 78-31 ..... 9

OTHER AUTHORITIES:

Patricia A. Butler, *Public Reimbursement of Nursing Homes — A Technical Guide for Resident Advocates* (Research Institute on Legal Assistance, Legal Services Corporation, 1980) ..... 13, 14, 15, 29

Comptroller General's Report to the Congress, "Entering a Nursing Home — Costly Implications for Medicaid and the Elderly" (November 26, 1979) ..... 29

Bruce Spitz, *Medicaid Nursing Home Reimbursement in New York* (The Urban Institute Press, 1980) .... 13, 14, 15, 29

## STATEMENT OF THE CASE

Petitioners' brief presents, for the most part, an objective and accurate statement of this case. However, a more extensive recitation of how the issues presented in this Court developed during the course of the litigation is necessary, particularly for a complete understanding of the justiciability question which petitioners have raised here for the first time.

From the beginning of this suit the respondents' challenge has been to the illegal discharge or transfer of Medicaid patients out of the skilled nursing facilities (hereinafter "SNFs") or the intermediate care facilities[1] (hereinafter "ICFs") in which they reside. In the First Amended Complaint and the three Intervenor Complaints, respondents, on behalf of themselves and a class of Medicaid patients, complained about those discharges or transfers insofar as they resulted from erroneous adverse determinations of Utilization Review Committees (hereinafter "URCs") that Medicaid patients no longer needed their current level of care and the affirmance of those determinations by the State Department of Social Services. The specific injury alleged in the complaints by each of the three original respondents (including the organizational respondent The Gray Panthers, New York Chapter, on behalf of its 5,000 members) and the ten intervenor-respondents[2] was their involuntary and illegal discharge or transfer from their nursing homes. (A. 21, 26, 27, 32, 53, 60-61, 64-5, 67-8, 70-71, 79, 82, 85, 88, 91).

The intervenor-respondents obtained temporary restraining orders against both petitioners and the proprietors and managers of their nursing homes enjoining their discharge or transfer

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[1] Intermediate care facilities are termed health related facilities, or HRFs, in New York State. (A. 168). References preceded by "A." are to the joint appendix in this case.

[2] Intervenor-respondent Pauline Ashkenazy has died since the time petitioners filed their petition for a writ of certiorari in this case.

from their facilities through implementation of the adverse URC determinations and State hearing decisions. (A. 41-2, 45-6). Following an evidentiary hearing and a written decision of the District Court, respondents obtained a preliminary injunction dated January 5, 1978 enjoining both petitioners and the proprietors and administrators of all SNFs and ICFs in New York State from discharging or transferring respondents and class members [3] out of their nursing facilities without minimal procedural safeguards. The preliminary injunction was affirmed by the Court of Appeals. 592 F.2d 65 (1979). (A. 99, 104, 122).

Subsequently, over the course of many months, attorneys for the respondents and petitioners negotiated a partial consent agreement, signed by the parties on May 29, 1979 and approved by the Court on October 19, 1979, which substantially improved the procedural protections for Medicaid nursing patients subjected to URC determinations to discharge them or transfer them to a lower level of care and which prohibited the implementation of such determinations unless voluntarily consented to by the patient. Over the course of these negotiations there were brought to the attention of respondents' attorneys several cases of facility threats, outside of the utilization review (UR) process, to summarily discharge Medicaid nursing patients. These particular threats were forestalled by the fortuitous intervention of legal services attorneys or representatives of the New York City Nursing Home Ombudsman Program, but they emphasized the very real danger, independent of the URC process and particularly if the URC route to involuntary patient moves were closed by agreement of the parties, that facilities themselves would initiate the involuntary discharge of patients.

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[3] The class had been certified to include all Medicaid patients in SNFs and ICFs in New York State who are subjected to adverse URC determinations and state hearing decisions that they are ineligible to remain in their current facilities. (A. 45).

The named respondents (including members of the respondent Gray Panthers) and the intervenor-respondents were, in particular, under an especially grave threat of facility-initiated discharge or transfer, without hearing safeguards. Once URC transfers were no longer possible, respondents' facilities would be armed with permanently unenforceable determinations by URC physicians that these patients were inappropriately placed there and should be discharged or transferred elsewhere. Those adverse URC determinations were based on completion of the State-created and State-prescribed long-term care assessment form, called the DMS-1, and they had been specifically affirmed by the State. Thus, the facilities themselves, instead of the URCs, now posed the threat of causing respondents the precise injury they had alleged in their complaints — their arbitrary and erroneous discharge or transfer from their nursing homes, this time without even the opportunity for a hearing.

Petitioners themselves acknowledged the dangers inherent in involuntary patient transfers, whatever their origin. Thus petitioners admitted, in their attorney's affidavit in the District Court, that they had agreed to permanently halt implementation of involuntary URC determinations because of the devastating and unpredictable patient trauma that accompanies any involuntary out-of-facility move:

> Defendants agreed to the inclusion of the provision regarding the necessity of patient consent to transfer for two reasons. First, there exists a widespread phenomena known as "transfer trauma" which is the anxiety experienced by an elderly patient when moved from or even faced with the threat of being moved from a nursing home which he has come to view as his home to another institution. Further, it appears that transfer trauma can cause a deterioration of the patient's health leading in some cases to his death. Secondly, it appears that there is at present no way to know which patients object to being transferred out of a facility will suffer from transfer trauma and which will not.

> Therefore, the State defendants concluded that, given the current state of medical understanding of transfer trauma, the only way to protect the patient's health is to require that he consent to any proposed out-of-facility transfer.

(A. 220-21).[4]

In joint recognition of the threat that after the halting of URC transfers nursing facilities would involuntarily move Medicaid patients on their own initiative, petitioners and respondents stipulated in the Joint Pre-Trial Order, signed by the District Court on March 5, 1979, to the formal addition of respondents' claims challenging these facility actions, to a statement of petitioners' policies regarding the facility actions, and to an amendment of the class definition. Thus the parties stipulated to the assertion of respondents' claims that patient discharges and transfers to a lower or higher level of care performed by facilities or their agents outside of the URC review process and facility transfers to a higher level of care pursuant to URC determinations must be preceded by the opportunity for the affected patient to obtain an evidentiary hearing, both under state action principles and the Fourteenth Amendment's Due Process Clause and under applicable federal and state "fair hearing" regulations. (A. 157, 166, 167). Petitioners stipulated to their current policy of refusing to provide hearings for Medicaid patients subjected to these discharges or transfers.[5] Peti-

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[4] Similarly, petitioner State Commissioner of Social Services Barbara Blum stated in a letter to the Regional Medicaid Director at the Department of Health and Human Services (undated, at page 2) that "New York State has determined that an involuntary Utilization Review transfer which requires a physical move out of a facility is medically contra-indicated." Defendants' Second Supplement to Joint Appendix in Court of Appeals, received 10/16/81.

[5] Petitioners' assertion (Brief, page 14) that a patient subjected to a facility-initiated discharge or transfer could request and obtain a URC determination and State hearing, although "not entitled" to either, is misleading. Petitioners stipulated in the Joint Pre-Trial Order that these patients

tioners further stipulated that during an earlier period they had conducted 10 hearings (with 5 reversals on the merits) of URC determinations to transfer patients to a higher level of care (A. 181), and that a number of the URC transfer decisions obtained by respondents in discovery were to a higher level of care (with 60 percent of them reversed on the merits after hearing). (A. 199, 205). Respondents alleged that a "substantial proportion" of facility-initiated transfers and URC transfers to a higher level of care "are not proper under applicable federal and state regulatory prohibitions against arbitrary discharge" (A-182) and "are used by facilities to rid themselves of patients they do not wish to retain" (A. 189). Finally, petitioners stipulated to, and the District Court certified, the expansion of the class definition to include "all residents of skilled nursing and health related facilities in New York State who are recipients of

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"do not have a right to prior notice and hearing" "although the patient may request that the decision be reviewed by the URC and, *upon such review*, are entitled to the procedural rights [of a hearing]." (emphasis added). (A. 181-82). Respondents' and petitioners' attorneys understood that language to mean what it says, namely, that URC review in these cases was not a matter of right and was not guaranteed. Affected patients were given no notice of even the right to request such URC review, and petitioners further stated that their policy of gratuitously honoring such requests, to the extent they were honored, was under review and "may stop." (A. 182). In his deposition, Anthony Maddaloni, Health Program Administrator in the Bureau of Long-Term Care Services of the State Department of Health, explained that a patient transfer directed by a private physician "doesn't go through the UR committee's functions." (A. 137). That statement is an admission of petitioners. (A. 208). Finally, a letter dated April 27, 1981 from Mr. Maddaloni to a nursing home administrator clarifies petitioners' policy by explaining that the URC is notified of a patient transfer occurring outside the URC review process only if, coincidentally, "the patient's [URC] continued stay review date corresponds with the [non-URC] physician's order." Copy of letter attached as Appendix B to "Plaintiffs' Brief in Opposition to Defendants' Petition for a Writ of Certiorari," dated June 17, 1981.

Medicaid benefits" (A. 151, 241-42), a class totalling about 95,000 persons. (A. 168).

The existence of class members who are actually threatened with such transfers was further confirmed by three letters from petitioners' agents which were provided to respondents' attorneys by petitioners' counsel and were attached as appendices to "Plaintiffs' Brief in Opposition to Defendants' Petition for a Writ of Certiorari," dated June 17, 1981. Two letters, dated December 18, 1980, are from Richard Ruid, Senior Social Services Program Specialist of the State Department of Social Services, identifying two respondent class members (Ewell Perry and Gilberta Kamen) recommended for transfer out of their nursing homes by their attending physicians and directing the local Department of Social Services to provide them with hearings in accordance with the District Court's Order in this case. The other letter, dated April 27, 1981, is from Anthony Maddaloni, Health Program Administrator in the Bureau of Long-Term Care Services of the State Department of Health, informing a nursing facility administrator that the patients whom the facility sought to discharge were entitled to agency hearings in this case.

Petitioners vigorously defended against respondents' facility discharge/transfer claims on the merits in both the District Court and the Court of Appeals. At no time in either of those courts did petitioners even suggest that these issues failed to present a justiciable controversy. The District Court ruled and the Court of Appeals affirmed that state action and the due process right to a prior evidentiary hearing attach to a facility's patient discharge or transfer to a lower or higher level of care, outside of the URC review process, and to a facility patient transfer to a higher level of care pursuant to an adverse URC determination. (A. 240, 241-43, 245-53). Only after losing twice on the merits of these issues did petitioners raise the justiciability question, for the first time, in this Court.

## STATUTORY AND REGULATORY SCHEME

Nursing facilities in New York State are comprehensively regulated in minute detail by an elaborate matrix of federal and state statutes, regulations, and administrative directives. It is through this network of federal and state laws that the State is closely involved in the nursing facilities' relationship with their Medicaid patients, from the point of their admission through the time of their discharge or transfer. These laws also constitute the primary bases for the finding the state action and statutory hearing rights in a nursing facility's involuntary discharge or transfer (to a lower or higher level of care) of a Medicaid patient. For the convenience of the Court, this statutory and regulatory scheme is presented here, as it bears upon the State's control over the facility's admission and discharge/transfer of Medicaid patients,[6] the State's identification of patients to be moved by the facility, the penalties for the facility's failure to move inappropriately placed patients, the State's responsibility to provide SNF/ICF care for Medicaid patients in the facilities of their choice, the State's responsibility for the correctness of the facility's action in discharging or transferring a Medicaid patient, the State's subsidizing of nursing facilities, and the Medicaid patient's federal and state law right to a hearing when discharged or transferred by a facility.

### A. State's Control Over Facility Admission And Discharge/ Transfer Of Medicaid Patients

An SNF or an ICF can admit and retain a Medicaid patient only on a physician's certification and periodic medical recertification of the patient's need for SNF or ICF services. Social Security Act, 42 U.S.C. §§ 1396b(g)(1) (A) and (B),

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[6] The nursing facility conduct that is governed by these federal and state laws is wholly independent of the review functions performed by URCs, which, except for URC determinations to transfer patients to a higher level of care, are not at issue in this Court.

1395x(j)(12); 42 C.F.R. §§ 442.306, 456.260(a) and (b), 456.270(a), 456.360(a) and (b), 456.370(a); 10 N.Y.C.R.R.[7] §§ 415.1(b), 730.2(b). The patient's appropriateness for admission to an SNF or ICF must be determined by the physician's application of the patient assessment criteria and the New York State Long Term Care Placement Form, called the DMS-1, devised and prescribed by the State Department of Health.[8] 10 N.Y.C.R.R. §§ 415.1(a), 420.1(b), 730.2(a), 740.2(b). The patient care plan which the SNF or ICF is required to develop promptly after the admission of the patient must contain a discharge plan that details the plans and steps for discharging or transferring the patient when he is determined to no longer require placement in that facility. 42 C.F.R. §§ 456.280, 456.371, 456.380; U.S. Department of Health and Human Services ("HHS") (Social and Rehabilitation Service) Medical Assistance Manual, § 5-60-20, pages 6, 9, 10, 45; 10 N.Y.C.R.R. §§ 416.1(K)(2)(ii), 421.3(b)(2), 731.1(K)(2)(ii), 740.6(p), 741.3(b)(2).

Each SNF or ICF is required to promptly discharge or transfer to a lower or higher level of care, without provision for a hearing, any Medicaid patient who is determined by the facility director, a facility staff physician, or the patient's attending physician to be inappropriately placed there because SNF or ICF care is no longer medically necessary or medically sufficient for the patient, the patient's behavior is dangerous or

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[7] Volume 10 of the New York Code of Rules and Regulations contains the official regulations of the New York State Department of Health.

[8] The DMS-1 form is "scored" by the assignment of points to patient conditions (such as "impaired judgment," "toileting," "wanders") according to the numerical scoring system promulgated by the Department of Health. The points for each patient are totalled to determine a "predictor score." The predictor score cut-off for an SNF is 180 points and above; the cut-off score for an ICF is 60 points and above. Patients failing to achieve the minimum score are determined to be inappropriately placed in their facilities. (A. 170).

unacceptable or disturbing to others, the patient is suffering from drug or alcohol addiction, or the patient suffers from a communicable disease. 42 C.F.R. § 442.307; HHS Medical Assistance Manual, § 5-60-20, page 45; 10 N.Y.C.R.R. §§ 415.1(b) and (i), 416.9(d), 420.1(a) and (i), 421.13(d), 704.1(b)(2), 730.2(b) and (i), 731.11(d), 740.2(a) and (i), 741.13(a)(3), 741.14(d); 18 N.Y.C.R.R.[9] § 505.20; New York State Department of Health: Hospital Memorandum 77-74 (8/17/77) (page 4), Health Facilities Memorandum 79-47 (8/27/79) (page 1 of "Questions and Answers").[10] Although a patient's refusal to move to a higher level of care pursuant to a URC determination does not result in the termination of the patient's Medicaid benefits, the facility is directed to arrange the move "as soon as possible." New York State Department of Social Services Administrative Directive[11] 78 ADM 31 (6/28/78) (Addendum #1, page 1). In determining whether a Medicaid patient is no longer appropriately placed in an SNF or ICF and should be discharged or transferred to a lower or higher level of care,[12] the SNF and ICF are mandated to utilize the detailed patient assessment standards and the DMS-1 long term care placement form devised and prescribed by the State Department of Health. 10 N.Y.C.R.R. §§ 416.9(d)(4), 421.13(d)(4), 731.11(d)(4), 741.14(d)(4); 18 N.Y.C.R.R.

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[9] Volume 18 of the New York Code of Rules and Regulations contains the official regulations of the New York State Department of Social Services.

[10] The New York State Department of Health issues formal and legally binding directives to SNFs and ICFs through its Hospital Memorandums and Health Facilities Memorandums.

[11] The New York State Department of Social Services issues formal and legally binding directives to local social services districts through its Administrative Directives.

[12] As indicated earlier, these facility review responsibilities are independent of the continued stay review functions of URCs, which are described at 42 U.S.C. §§ 1396b(g)(1)(c), 1395x(K); 42 C.F.R. §§ 405.1137, 456.400.

§ 505.20(b)(4); New York State Department of Health: Hospital Memorandums 77-9 (1/31/77), 77-10 (2/9/77), 77-13 (2/11/77). In order to facilitate the transfer of patients, the SNF or ICF that is to receive the patient is directed to accept him based on the transferring facility's completion of the DMS-1 form. Hospital Memorandums 77-60 (7/5/77) (page 2), 77-74 (page 1).

**B. State's Identification Of Patients To Be Moved By The Facility**

The State Department of Health is required to send medical review teams to conduct annual on-site inspections of all SNFs and ICFs (called Periodic Medical Reviews, or PMRs, for SNFs, and Independent Professional Reviews, or IPRs, for ICFs), during which individual medical reviews are performed on each SNF and ICF patient specifically to assess the appropriateness of his continued placement in the facility. 42 U.S.C. §§ 1396a(a)(26), 1396a(a)(31), 1396b(g)(1)(D); 42 C.F.R. § 456.600 *et seq*. In its report to the Department of Health, the medical review team identifies particular patients whose continued placement in their SNF or ICF facilities is determined to be inappropriate and recommends their discharge or their transfer to a lower or higher level of care. 42 C.F.R. § 456.611; HHS Medical Assistance Manual, § 5-60-20, pages 2, 19, 23-24, 26. A copy of that report is sent to facilities with inappropriately placed patients and the facilities are expected to comply with the State medical team's recommendations to relocate identified patients. 42 C.F.R. § 456.612; HHS Medical Assistance Manual, § 5-60-20, page 29; Health Facilities Memorandum 80-54 (5/16/80) (page 2).

**C. Government-Created And State-Enforced Penalties For Facility's Failure To Discharge Or Transfer Patients**

SNFs and ICFs that fail to move patients considered to be inappropriately placed are subject to the imposition of substantial penalties in the form of fines, non-reimbursement for services rendered, and suspension from participation in the Medi-

caid program. 42 U.S.C. § 1396h; 42 C.F.R. §§ 420.100 *et seq.*, 431.54(f) (adopted October 1, 1981); HHS Medical Assistance Manual, § 60-90-20, pages 3-6; New York Social Services Law § 367(2); New York Public Health Law §§ 2803(6) and (7), 2897 *et seq.*; 18 N.Y.C.R.R. §§ 505.9(u), 505.20(b)(2) and (5), 515.2, 515.3, 516.1, 540.8(g); 10 N.Y.C.R.R. § 414.18, Part 742.

**D. State's Responsibility To Ensure Continuing Provision Of Appropriate SNF or ICF Services For All Eligible Medicaid Recipients In Facilities Of Their Choice**

The *State* is obligated to provide SNF services and (since it has undertaken to make them available) ICF services to all Medicaid recipients over 21 years of age, an obligation it discharges through nursing facilities. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(A) and (5), 1396d(a)(15); 42 C.F.R. § 405.1133. The *State* is obligated to ensure the provision of these SNF and ICF services equally in amount, duration, and scope for all eligible Medicaid recipients age 21 or older, subject only to the *State's* right to limit services based on medical necessity and appropriateness. 42 U.S.C. § 1396a(a)(10)(B)(i); 42 C.F.R. §§ 440.210, 440.230(c)(2), 440.240, 440.250(a).

The *State* is required to secure the right of all eligible Medicaid recipients to continue to obtain assistance from the SNFs or ICFs they have chosen, once those facilities have undertaken to admit them. 42 U.S.C. § 1396a(a)(23). The State is also responsible for securing the rights of SNF and ICF patients to be free of involuntary discharge or transfer to a lower or higher level of care by their facilities except for valid medical reasons or for their welfare or that of other patients and with due regard to their right to refuse treatment. 42 C.F.R. §§ 442.1(a), 442.202(c), 405.1121(K)(4), 442.311(b)(1)(iii), 442.311(c); New York Social Services Law §§ 364(2)(a) and (b), 364-a(2); New York Public Health Law §§ 2803-c(1), 2803-c(3)(e); 18

N.Y.C.R.R. § 360.29; 10 N.Y.C.R.R. §§ 414.14(4), 730.17(4), 740.14(4).

### E. State's Responsibility For Correctness Of All Patient Discharges/Transfers And Of The Medicaid Decisions Based Thereon

#### 1. Facility admission/discharge decisions

Officials of the New York State Departments of Health and Social Services are responsible under federal and state law for the validity of *all* decisions to admit Medicaid recipients to and to discharge or transfer them from SNFs or ICFs, and that responsibility cannot be delegated to private entities. 42 C.F.R. §§ 431.10(e), 435.403, 435.930, 456.271, 456.372; HHS Medical Assistance Manual, § 5-60-20, page 46; New York Public Health Law § 2801(1), 2803(1)(d); New York Social Services Law §§ 367(1) and (2), 367-c(1); 10 N.Y.C.R.R. §§ 415.1(a), 731.11(f)(2) and (3), 741.14(f); 18 N.Y.C.R.R. §§ 505.9(b)(1) and (2), 540.1, 540.4, 540.5, 540.5(a)(5)(i); Hospital Memorandums 77-10 (page 5), 77-60 (pages 1, 2, 3), 77-74 (page 8). SNFs and ICFs are required to submit to the State Department of Health for its review and approval all completed DMS-1 forms upon which facilities base their discharge or transfer of patients. Hospital Memorandums 76-135 (12/16/76) (page 3), 77-35 (4/11/77), 77-60 (pages 2 and 4); Health Facilities Memorandum 79-23 (4/27/79) (pages 2, 4).

#### 2. Medicaid decisions

Federal and state law also impose upon the State Department of Social Services the non-delegable duty to review for correctness all determinations, including facility discharges/transfers of Medicaid patients, upon which Medicaid eligibility or benefit adjustment decisions are based. 42 U.S.C. § 1396a(a)(5); 42 C.F.R. §§ 431.10(c) and (e), 431.11(d), 435.916(c); New York Social Services Law §§ 65(5)(b) and (d), 366-a(5) and

(6); 18 N.Y.C.R.R. §§ 351.21(f)(6) and (7), 351.22(d), 351.22(e), 351.22(e)(2); 358.9(a) and (b).

**F. State's Subsidizing Of Nursing Facilities**

The State must make reasonable and adequate reimbursement payments to SNFs and ICFs for services rendered to Medicaid patients, including all items of expense incurred by facilities in meeting federal definitions and standards and in complying with state health standards and licensing requirements. 42 U.S.C. § 1396a(a)(13)(A); 42 C.F.R. §§ 447.279, 447.302, 447.303. New York State supplies more than 90 percent of the patients in SNFs and ICFs (A. 169) and subsidizes both the operating costs and capital expenditures of those facilities. Allowable costs that are fully reimbursed by the State include all items of provider expense that are attributable to patient care, including all regular room, dietary and nursing services; the cost of physician and surgical supplies; the use of equipment and facilities; all items furnished routinely to patients such as patient gowns, water pitchers, basins, and bedpans; items distributed or used individually in small quantities such as cotton balls, bandaids, aspirin, and tongue depressors; items used by individual patients such as ice bags, crutches, and wheelchairs; laundry services; drugs; salaries; housekeeping and maintenance services; and social work and leisure activities. 42 C.F.R. §§ 447.281, 447.331. *See Public Reimbursement of Nursing Homes — A Technical Guide for Resident Advocates,* Patricia A. Butler (Research Institute on Legal Assistance, Legal Services Corporation, 1980) (hereinafter "Butler"), pages 83-4; *Bruce Spitz, Medicaid Nursing Home Reimbursement in New York* (The Urban Institute Press, 1980) (hereinafter "Spitz"), page 64. Rates are set prospectively and are adjusted upward for inflation and for newly enacted laws affecting costs. Spitz, page 64; Butler, pages 56-7 and Chart A.

The State fully reimburses the facility owner for the costs of his capital assets including the interest on mortgage payments, maintenance expense, taxes and depreciation on his real estate, and the depreciation on his buildings and fixed equipment. Further, where the owner of a proprietary facility invests capital in purchasing land, buildings, and equipment, the State reimburses him for the "cost" of that investment by guaranteeing him a return on his investment. As authorized by federal law, New York State provides the facility owner with a return on net invested equity at the Medicare rate, which was about 13.5 percent in 1979 and about 15 percent in 1980. Spitz, pages 7, 10, 43, 81, 82; Butler, pages 22, 24, 25, 31, 56-7, 65, 72, 77, 80.

The State pays a profit on a proprietary provider's investment at a market-related price in order to attract and maintain private investment in nursing homes. Voluntary or non-profit facilities can also realize efficiency profits by keeping their actual operating costs below the reimbursement ceilings set by the State. 43 Fed. Reg. 4861 (2/6/78). The New York State reimbursement system provides additional profits to non-profit facilities by allowing them to keep the difference between their actual costs and the prospective rate and by awarding facilities with high quality ratings more than 100 percent of their average group rate. Spitz, page 64; Butler, pages 56-7 and Chart A. Non-profit facilities are further subsidized by exemption from income, property, and sales taxes and have access to capital funding through government loan and grant programs. New York State provides facilities with construction funds through the State Housing Finance Company. Public Health Law Article 28A. Finally, additional profit inheres in the fact that capital costs for proprietary facilities — including interest, maintenance, taxes, and depreciation on land, plant, and fixed equipment — are not only fully reimbursed by the State but tax deductible as well. Thus much of the cash income generated by Medicaid is shel-

tered from taxation. Spitz, pages 10-11; Butler, pages 20, 25, 26, 27, 44, 54, 62, 72, 91.

### G. Federal And State Law Provisions Entitling Discharged Or Transferred Medicaid Patients To State Hearings When State Terminates Or Reduces Medicaid Benefits

Applicable federal and state law provisions entitle a Medicaid recipient to notice and a state agency "fair hearing" whenever the agency takes "action" to reduce or terminate Medicaid eligibility or covered services, including when that agency "action" is based on a nursing facility's discharge or transfer of a Medicaid patient. 42 C.F.R. §§ 431.200, 431.201, 431.213(f) (agency hearing when "a change in the level of medical care is prescribed by the recipient's physician"), 431.220, 435.919; HHS Medical Assistance Manual, § 5-100-20, page 2 ("[a] recipient who believes that his free choice of provider has been denied or impaired has the right to request a fair hearing before the State agency"); New York Social Services Law §§ 22(1) and (3) and (5), 22(5)(c) and (d); 18 N.Y.C.R.R. §§ 351.23(a) and (b), 355.3(a)(2) and (b)(1), 358.3, 358.4(a), 358.5(a), 358.8(a)(1), 358.8(d)(1)(iv), 358.8(d)(1)(viii),[13] 360.18(a)(1); 10 N.Y.C.R.R. § 730.17(c).

## SUMMARY OF ARGUMENT

This case clearly presents a justiciable controversy since the named respondents and intervenor-respondents ("respondents") were threatened with the injury of arbitrary and summary discharge or transfer by the nursing facilities in which they reside. As alleged in respondents' complaints, the injury of involuntary discharge or transfer from their nursing facilities was initially threatened by the facilities' implementation of erroneous adverse URC determinations that respondents were

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[13] Proposed to be withdrawn, by State Department of Social Services notice dated December 29, 1981.

inappropriately placed and should be moved. With the petitioners' agreement in this case to forbid the implementation of all URC determinations to discharge Medicaid patients or transfer them to a lower level of care, respondents became subject to the distinct threat that the facilities would arbitrarily move them on their own initiative. The threat was concrete, since these now unenforceable determinations had been rendered by the facilities' own URC physicians and affirmed by the State, the URC determinations were based on completion of the State-prescribed DMS-1 long-term care assessment form, and the State by law required the facilities themselves to initiate the discharge or transfer of all inappropriately placed patients on the basis of a completed DMS-1 form without provision for a hearing. On these facts and circumstances, respondents were threatened with injury from facility-initiated discharges or transfers and therefore had, and continue to have, a "personal stake" in the controversy concerning whether state action and the due process right to a hearing attach to facility discharges or transfers of Medicaid patients sufficient to give them standing to sue. *United States Parole Comm'n* v. *Geraghty*, 445 U.S. 388 (1981); *Gladstone, Realtors* v. *Village of Bellwood*, 441 U.S. 91 (1979); *Truax* v. *Raich*, 239 U.S. 33 (1915).

Furthermore, petitioners expressly stipulated in this case to the assertion and adjudication of respondents' claims challenging summary facility discharges/transfers, and to the amendment of the class definition to encompass those claims. Petitioners strenuously contested those claims on the merits in both the District Court and the Court of Appeals and raised the justiciability issue for the first time in this Court.

Under the principles set forth in this Court's state action decisions, state action, and hence the hearing requirements of the Fourteenth Amendment's Due Process Clause, clearly attach to a nursing facility's discharge of a Medicaid patient or his transfer to a lower or higher level of care, outside of the

URC review process, and to his transfer to a higher level of care pursuant to a URC determination. State action flows, first, from the nexus between the State and the private conduct which is created by the State's close and comprehensive control by law over the facility's discharge or transfer of a Medicaid patient. The State requires that an SNF or ICF must evaluate, independent of URC review, every patient's continuing need to stay in the facility, using the State's standards and the State's DMS-1 assessment instrument. The State requires that the facility promptly discharge or transfer, without a hearing, all patients thus identified as inappropriately placed and then adjusts the Medicaid benefits of the Medicaid patients moved in this manner by the facility. The State also sends medical review teams to each SNF and ICF to identify patients whom the facility is expected to move. Finally, the State directs the receiving facility to accept the transferred patient based on the DMS-1 form as completed by the transferring facility. Failure of the facility to move inappropriately placed patients subjects it to State-prescribed and State-enforced penalties. The State's commanding and sanctioning of the nursing facility's discharge or transfer of a Medicaid patient plainly creates state action here and supplies the critical factor lacking in the cases in which this Court has found no state action in challenged private conduct. *Polk County* v. *Dodson*, 50 U.S.L.W. 4077 (December 14, 1981); *Flagg Brothers, Inc.*, v. *Brooks*, 436 U.S. 149 (1978); *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974); *Moose Lodge No. 107* v. *Irvis*, 407 U.S. 163 (1972).

There are present as well a number of additional forms of state approval of and responsibility for the facility's discharge or transfer of Medicaid patients. The State is legally obligated to provide appropriate SNF or ICF services for all eligible Medicaid recipients in the facility of their choice. Further, the State is legally obligated to approve or disapprove on the merits every facility discharge or transfer of a Medicaid patient when it

occurs and, as well, when the State adjusts the patient's Medicaid eligibility.

State action also inheres in the symbiotic relationship between the State and the facilities which makes the State a joint participant in the facilities' discharge or transfer of Medicaid patients. *Burton* v. *Wilmington Parking Authority*, 365 U.S. 715 (1961). The State reimburses the facility for practically all of its operating and capital costs, guarantees it a profit, and provides more than 90 percent of its patients. The facilities, on the other hand, satisfy the State's legal obligation and public function of providing SNF and ICF services for all eligible Medicaid recipients.

Finally, applicable statutory and regulatory provisions of federal and state law independently require the State to provide a hearing for any Medicaid recipient whose Medicaid benefits are reduced or terminated on the basis of his discharge or transfer by a nursing facility.

## ARGUMENT

### POINT I

#### The Case Presents A Justiciable Controversy

This case presents a justiciable controversy since the respondents satisfy the minimum "personal stake" requirement of Article III of the Constitution that they "personally . . . suffered some actual or threatened injury as a result of the putatively illegal conduct of the defendant." *Gladstone, Realtors* v. *Village of Bellwood*, 441 U.S. 91, 99 (1979); *United States Parole Comm'n* v. *Geraghty*, 445 U.S. 388, 396 (1981). As explained in the "Statement of the Case," page 1, the named respondents (including the original two named respondents, the named organizational respondent The Gray Panthers on behalf of its members, and the ten intervenor-respondents) all alleged in their complaints injury from wrongful discharge or transfer by their nursing homes, then originating from adverse URC

determinations and State fair hearing decisions.[14] Later, temporary restraining orders, a preliminary injunction, and a partial consent judgment were obtained that halted, first temporarily and then permanently, the implementation of all of these adverse URC determinations.[15] However, the threatened injury of the respondent's wrongful discharge or transfer by their nursing homes continued to exist, because of the likelihood that the facilities themselves, instead of the URCs, would initiate the patient moves without adequate procedural safeguards.[16]

The immediacy of this threat of respondents' summary relocation at the initiative of their facilities was self-evident. URC physicians in the facilities had determined that the respondents were inappropriately placed there and should be moved, and those determinations had been affirmed by the State Department of Social Services.[17] Those determinations were based on

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[14] It is the nursing facility that actually discharges or transfers the patient, whether the patient move be prompted by a decision of the URC, the attending physician, the facility staff physician, or the facility operator or medical director. See mailgram from facility administrator, introduced into evidence at preliminary injunction hearing, threatening to immediately transfer several named respondents following adverse URC determinations. (A. 96-7).

[15] Since it was the nursing facility's actual relocation of the patient that constituted the injury that respondents sought to prevent, the temporary restraining orders and preliminary injunction included prohibitions against discharge or transfer of the respondents and class members by the proprietors and administrators of their nursing homes. (A. 41-2, 100-101, 116).

[16] Respondent Gray Panthers derived its standing to sue from allegations in the first amended complaint that some of its 5,000 members were injured by involuntary transfers or threats of such transfers. (A. 21). *Cf. United States* v. *SCRAP*, 412 U.S. 669, 688 (1973).

[17] Moreover, the attending physicians of respondents Foley, Ashkenazy, Birenzweig, Zahl, and Kolman had declined to exercise their right under law to initially object to the adverse URC determinations. See DMS-1s attached to respondents' affidavits in support of applications for temporary restraining orders. Record on appeal docket numbers (hereinafter "R.A. Doc. No.") 12, 15.

the completion of the State-prescribed DMS-1 long-term care assessment form, using the State's standards. The facilities were under a State-imposed mandate to evaluate all patients, using that same DMS-1 instrument, and to promptly discharge or transfer, without a hearing, patients identified as inappropriately placed. Failure of the facilities to move respondents might subject them to substantial penalties under law, including fines, non-reimbursement for services rendered, and suspension from the Medicaid program. See "Statutory and Regulatory Scheme" (hereinafter "Statutes"), pages 7-11.

Under these circumstances, it was apparent that the URC determinations and facility-initiated actions to move the respondents were virtually interchangeable,[18] and that there existed a distinct and palpable threat that the respondents' facilities would in effect convert these unenforceable erroneous URC determinations into their own decisions to discharge or transfer the respondents without a hearing, *Cf. Traux* v. *Raich*, 239 U.S. 33, 38-9 (1915) (alien employee has standing to challenge constitutionality of Arizona statute which imposed penalties upon companies employing more than 20 percent aliens). Finally, petitioners' agents have identified in writing particular class members who would have been summarily transferred by their facilities in the absence of the injunction in this case prohibiting such transfers without a hearing. See "Statement of Case," page 6.

Furthermore, petitioners expressly stipulated in this case to the addition to this suit of respondents' claims that facility discharges or transfers are state action and must be accompanied by the opportunity for a hearing. Petitioners acknowledged that involuntary patient relocations are always a threat to the patient's health. They stipulated to their policy of failing to

[18] The doctors were interchangeable as well, since attending physicians in a facility are often URC physicians for other patients in the same facility. (A. 173); Maddaloni Deposition, pages 66-7. (R.A. Doc. No. 98).

ensure hearings in cases of facility discharges or transfers to a lower level of care or URC determinations that a patient should be transferred to a higher level of care, and they agreed to an expanded definition of the class. They stipulated to respondents' assertion of claims challenging the validity of these discharges or transfers without the patient's right to a hearing [19] and expressly agreed to the District Court's adjudication of these claims. See "Statement of the Case," pages 4-6. Petitioners vigorously contested these claims on the merits, with no suggestion of any justiciability problem, in both the District Court and the Court of Appeals, and the issues come to this Court sharply presented by "self-interested parties advocating opposing positions." *United States Parole Comm'n, supra,* 445 U.S. at 403.

Under the facts and circumstances of this case, respondents submit that both the Article III limitations and the prudential aspects of the case and controversy requirement are satisfied here and that this Court should decide the merits of the issues presented.

## POINT II

### State Action Attaches To A Nursing Facility's Discharge Or Transfer Of A Medicaid Patient

It is important at the outset to dispel the serious misimpression fostered by petitioners in their Brief to this Court that the issue in this case is whether a doctor's medical decision to alter the treatment of his Medicaid patient is state action. That suggestion is fundamentally in error. From the beginning of this lawsuit the respondents' challenge has been to the involuntary discharge or transfer of Medicaid patients from and by their nursing facilities without adequate safeguards, initially as a

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[19] Respondents further alleged that these patient transfers were erroneous under law and were used by facilities to rid themselves of undesirable patients. (A. 182, 189).

consequence of adverse URC determinations. (A. 19, 22, 33, 48, 56, 74-5). Later, by stipulation between the parties, the respondents' challenge was to the nursing facility's summary discharge of patients or their transfer to a lower or higher level of care, independent of URC review, and to a higher level of care pursuant to a URC determination. (A. 157, 166-7, 234-5). Thus, the claim before this Court is whether state action attaches to a *nursing facility's summary discharge or transfer of the patient*, whether that facility action springs from the medical decision of a facility staff physician, the patient's attending physician, the facility medical director, or (in some transfers to a higher level of care) a URC determination, or from a purely non-medical decision of the facility operator that the patient is troublesome, antisocial, disturbed, or just plain undesirable. [20] A physician's medical decision that does not culminate in the facility's involuntary discharge or transfer of the Medicaid patient is not, and never was, the subject of respondents' claims. [21]

Application of the principles of this Court's state action decisions to the circumstances of this case compels a finding of state action when a nursing facility discharges a Medicaid patient into the community or an Adult Home [22] or transfers a

[20] Accordingly, the District Court's partial final judgment enjoined the *nursing facility's* discharge or transfer of a Medicaid patient without the opportunity for a state hearing. (A. 242-3).

[21] Thus, contrary to petitioners' suggestion (Brief, pages 37-8), respondents do not claim state action in a physician's decision to change his patient's drug prescription or to continue or withdraw the patient's chemotherapy treatment. On the other hand, respondents argue that state action attaches to *all* involuntary out-of-facility transfers by nursing facilities, including the unusual transfers highlighted by petitioners in their Brief (pages 38-9).

[22] Adult Residential Care Facilities, or Adult Homes, are not medical facilities, are not permitted to provide medical or nursing services, sometimes mix elderly patients with ex-mental patients and alcoholics, and are not equipped to handle a wide range of patient impairments and needs. (A.

patient to a lower or higher level of care, outside of the URC review process, and when a facility transfers a patient to a higher level of care pursuant to a URC determination. The state action finding flows ineluctably, first, from the direct nexus between the State and the private conduct created by the State's direct control and direction over the facility discharge/transfer action and, second, from the unique mutual interdependence between the State and the nursing facility and the public function served by the facility in caring for Medicaid patients. [23]

**A. Nexus between State and nursing facility conduct**

The crucial factor that is present in this case, and was notably absent from the cases in which this Court found no state action

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176-7); deposition of Elizabeth Dinehart, Regional Director of the Division of Adult Residential Care of the State Department of Social Services, pages 13, 16-20, 23-28. Ms. Dinehart's deposition statements are admissions of the petitioners. (A. 208). (R.A. Doc. No. 95).

[23] The consequence of the finding of state action here is only to trigger the requirement of the Fourteenth Amendment's Due Process Clause that Medicaid patients have the right to obtain a state agency hearing before the facility can discharge or transfer the patient. At the hearing the issue under federal and state law will be whether or not the facility is properly discharging or transferring the patient for valid medical reasons, for the welfare of the affected patient or other patients, or for non-payment for his stay (42 C.F.R. §§ 442.202(c), 405.1121(k)(4), 442.311(c); 10 N.Y.C.R.R. §§ 414.14(4), 730.17(4), 740.14(4)), and consistent with the patient's "right to refuse treatment" (42 C.F.R. § 442.311(b)(1)(iii); Public Health Law § 2803-c(3)(e); 10 N.Y.C.R.R. § 740.14(4)) and to be free of discharge solely because of his Medicaid status (10 N.Y.C.R.R. §§ 730.2(1), 740.2(k)). The validity of the purported medical reasons for the patient move will be measured against the very detailed standards for necessary skilled nursing or intermediate care facility services set forth in federal and state regulations. 42 C.F.R. §§ 440.40(a), 405.127-128a; federal Medical Assistance Manual, § 5-60-20 (pages 33-46); State Department of Health: Hospital Memorandums 77-9 (1/31/77), 77-10 (2/9/77) and 77-13 (2/11/77).

in challenged private conduct,[24] is the State's affirmative command that the nursing facility perform the very conduct in question — the summary discharge or the transfer to a lower or higher level of care of a Medicaid patient who is thought to be inappropriately placed in that facility. That affirmative command takes the form of the requirement under federal and state law that the facility first identify, using State standards and the State-created DMS-1 long-term care assessment instrument, patients whose continued stay is medically or socially inappropriate, and then promptly discharge those patients or transfer them to an appropriate facility without a hearing. See "Statutes," pages 7-10. The State Department of Social Services then terminates, reduces or increases the Medicaid patient's benefits on the basis of that facility action. (A. 169).

Pursuant to federal and state law, the State also sends medical review teams annually to every SNF and ICF to determine each patient's need for continued stay, notifies the facility of identified patients who should be moved, and directs the facility to discharge or transfer those patients. See "Statutes," page 10; deposition of Anthony Maddaloni, page 44 and A. 135-6, 143-5; Joint Pre-Trial Order (A. 193-4). The State command that an ICF move an inappropriately placed patient to an SNF is further reinforced when the URC determines that the patient should be transferred to the higher level of care. See "Statutes," page 9. The State solidifies its control over the facility transfer action by directing that the nursing facility which is to receive the transferred patient should accept that patient based on the

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[24] *Polk County* v. *Dodson*, 50 U.S.L.W. 4077 (December 14, 1981) (public defender's representation of his client); *Flagg Brothers Inc.* v. *Brooks*, 436 U.S. 149 (1978) (warehouseman's sale of stored property); *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974) (public utility's summary termination of customer's electric service for non-payment); *Moose Lodge No. 107* v. *Irvis*, 407 U.S. 163 (1972) (private club's exclusion of Blacks).

proper completion of the State DMS-1 form by the transferring facility. See "Statutes," page 13. The facility's failure to discharge or transfer an inappropriately placed patient subjects that facility to State-prescribed and State-enforced penalties, including fines, non-reimbursement for services rendered, and suspension from participation in the Medicaid program. See "Statutes," page 10.

Under the decisions of this Court it is beyond cavil that the nexus created between the State and the private conduct by this State requirement, sanctioning, and enforcement of the private conduct in question is state action under the Fourteenth Amendment. *Moose Lodge No. 107* v. *Irvis*, 407 U.S. 163, 172 (1972) ("Our cases make clear that the impetus for the forbidden discrimination need not originate with the State if it is state action that enforces privately originated discrimination.") Thus in *Moose Lodge* this Court readily found state action in the regulation of the Pennsylvania Liquor Control Board that, though "neutral in its terms," required a private club to adhere to its racially discriminatory membership rules. *Id.*, at 177-9. *Contrast Polk County* v. *Dodson*, 50 U.S.L.W. 4077 (December 14, 1981) (State imposes no command or control over the public defender's representation of his client); *Flagg Brothers, Inc.* v. *Brooks*, 436 U.S. 149, 166 (1978) ("[T]he State of New York has not compelled the sale of a bailor's goods, but has merely announced the circumstances under which its courts will not interfere with a private sale."); *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 357 (1974) (The Pennsylvania Public Service Commission "has not put its own weight on the side of the proposed practice by ordering it. . . . [a]t most the Commission's failure to overturn this practice amounted to no more than a determination that a Pennsylvania utility was authorized to employ such a practice if it so desired.")

The state action finding in this case is confirmed by the presence of additional forms of the State's responsibility for, and its encouragement and approval of, the facility's discharge or transfer to a lower or higher level of care of Medicaid patients who are viewed as undesirable or inappropriately placed. The State Department of Health is legally obligated to evaluate and to approve or disapprove on the merits the facility's decision to discharge or transfer the patient, including the completed DMS-1 form on which the facility action is based. [25] See "Statutes," page 12. Federal and State law also require the State Department of Social Services to review and approve on the merits the facility discharge/transfer decision which is the basis for the Department's adjustment of the patient's Medicaid eligibility. See "Statutes," page 12. *Cf. Public Utilities Comm'n* v. *Pollack,* 343 U.S. 451 (1952) (state action found in regulatory agency's affirmative approval of the challenged practice of the local transit system).

The action of the State Department of Social Services in adjusting the patient's Medicaid benefits on the basis of the facility's discharge or transfer of the patient supplies overt official involvement in and additional impetus for the facility's action. [26] *O'Bannon* v. *Town Court Nursing Center,* 447 U.S.

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[25] David B. Davidoff, Assistant Director of the Facility Surveillance Group in the Department of Health, in his affidavit of December 30, 1977 in this case confirmed (at paragraph 14) that "all DMS-1 forms completed by skilled nursing homes and intermediate care facilities" must be filed with the Department of Health, which "reviews DMS-1 forms to assure that they are properly completed." Plaintiffs' Exhibit 10, preliminary injunction hearing (1/4-1/5/78). Respondents' comprehensive study and analysis of more than 1500 DMS-1s completed by URCs showed a shockingly high rate of error in assessing patients' needs for their current level of care. (A. 199-204).

[26] See deposition of Richard Ruid, Senior Social Services Program Analyst in the Division of Medical Assistance of the State Department of Social Services, pages 55, 56 (A. 208); telegram of nursing home administrator threatening to transfer named respondents unless State continued Medicaid payments. (A. 96).

773, 786-7 (1980) ("The Government cannot withdraw these direct [Medicaid financial] benefits without giving the patients notice and an opportunity for a hearing on the issue of their eligibility for benefits."); *North Georgia Finishing, Inc.* v. *Di-Chem, Inc.*, 419 U.S. 601 (1975); *Fuentes* v. *Shevin*, 407 U.S. 67 (1972); *Sniadach* v. *Family Finance Corp.*, 395 U.S. 337 (1969) (state action in court clerks' participation in private enforcement of creditor pre-judgment remedies). *Contrast Flagg Brothers, supra*, 436 U.S. at 157 (noting the "total absence of overt official involvement" in the warehouseman's enforcement of his lien on stored property).

The State's legal obligations that attach when a nursing facility relocates a Medicaid patient include its responsibility to provide SNF and ICF services to all eligible Medicaid recipients, to assure each eligible patient his freedom to remain in a nursing facility which has accepted him, and to secure each nursing patient's right to be discharged or transferred only for specified cause. See "Statutes," pages 11-12. These obligations make it legally impossible for the State to remain neutral when a nursing facility involuntarily discharges or transfers a Medicaid patient. The State's asserted neutrality also cannot withstand petitioners' acknowledgment in this case that the trauma that accompanies any involuntary patient relocation is so unpredictable and so devastating that "the only way to protect the patient's health is to require that he consent to any proposed out-of-facility transfer."[27] (A. 220-21). See "Statement of Case," pages 3-4.

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[27] David Glaser, Administrator of the Margaret Tietz Center for Nursing Care, observed in his deposition in this case (pages 47, 48) that a patient's move from a lower to a higher level of care can be even more traumatic than movement downward, "because they know, if they get moved from the HRF to the SNF, they might be dying, and, so, that's a very deep emotional problem for the patient . . ." (R.A. Doc. No. 101).

Petitioners have also admitted in this case that they turned down the recommendations of their own Task Force to eliminate the patient trauma of

Therefore, it is clear under this Court's decisions that state action lies here in the State's direct control over and responsibility for the nursing facility's discharge or transfer of a Medicaid patient.

**B. Symbiotic relationship between state and nursing facility and facility's exercise of public functions.**

A finding of state action is equally compelled in this case by the extent and nature of the mutually beneficial, or symbiotic, relationship between the State and the nursing facilities that makes the State a "joint participant" in the facility's summary discharge or transfer of a Medicaid patient. *Burton* v. *Wilmington Parking Authority*, 365 U.S. 715 (1961). In *Burton*, state action was based on the finding that the State was a "joint participant" in the racially discriminatory practices of a restaurant that was located in a publicly owned and financed parking facility and which "constituted a physically and financially integral and, indeed, indispensable part of the State's plan to operate its project as a self-sustaining unit," *Id.*, at 723-4. The degree of mutual interdependence between State and private entity is even more striking here — each is virtually indispensable to the other. The State subsidizes practically all the operating and capital costs of the facility (including the salaries of its employees and the costs of the land, building, and

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out-of-facility transfers by encouraging the creation of more multi-level facilities containing both SNF and ICF levels of care. In his deposition in this case, Dr. Roger Herdman, Director of Public Health in the State Department of Health and a member of that Task Force, described the conclusions of the Task Force that involuntary patient transfers out of their facilities are "difficult, often inhuman and very often dangerous" and that the State should encourage the building of multi-level facilities. Deposition, pages 20, 21. But Dr. Herdman observed that although the State Legislature responded to the Task Force recommendations by giving the Commissioner of Health the authority to reclassify nursing homes to multi-level facilities, no such departmental action was taken. Deposition, pages 22, 23, 25. See A. 197-8, 208. (R.A. Doc. No. 100).

fixed equipment), supplies the facility with more than 90 percent of its patients (A. 169), and guarantees the owner a profit. See "Statutes," pages 13-15. The nursing facility literally depends upon the State for its very survival. Moreover, through its certificate of need and reimbursement policies the State rations the number and location of Medicaid nursing homes, creates and perpetuates a scarcity of nursing beds, and confers upon the facilities an artificial monopoly free of risks and competition in the provision of Medicaid nursing services.[28] *Contrast Jackson, supra,* 419 U.S. at 352 and n.8 (utility company's monopoly over provision of electric services was neither State-created nor free of competition); *Moose Lodge, supra,* 407 U.S. at 177 (private clubs lack monopoly over dispensing of liquor). Thus, the State "has elected to place its power, property and prestige" behind the actions of the facilities in summarily removing Medicaid patients.[29] *Burton, supra,* 365 at 725.

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[28] *See Public Reimbursement of Nursing Homes — A Technical Guide for Resident Advocates,* Patricia A. Butler (Research Institute on Legal Assistance, Legal Services Corporation, 1980) (hereinafter "Butler"), pages 15, 18, 19, 37-8, 58, 66; Bruce Spitz, *Medicaid Nursing Home Reimbursement in New York* (The Urban Institute Press, 1980) (hereinafter "Spitz"), pages 48, 83. Petitioners have admitted that their halting of implementation of adverse URC determinations exacerbates the already serious shortage of nursing beds in the State (occupancy rate of 93 percent upstate and 91 percent downstate). (A. 135, 170, 191). This State-created and State-fostered scarcity of nursing beds significantly increases the incentives for facilities to discharge or transfer Medicaid patients and to replace them with more profitable private pay patients. Butler, pages 18, 19, 35, 38; Spitz, page 83; Comptroller General's Report to the Congress, "Entering a Nursing Home — Costly Implications for Medicaid and the Elderly" (November 26, 1979), page 103.

[29] Of course, transfer actions of the approximately 12 percent of the nursing facilities in New York State that are publicly owned and run are automatically state action. Spitz, page 19. *Memphis Light, Gas and Water Division* v. *Craft,* 436 U.S. 1 (1978).

On the other hand, the State depends implicitly upon the facilities to discharge the inherently governmental function, as set forth in the Social Security Act and the State Constitution and laws, of providing institutional nursing services for the State's indigent citizens. The State is made responsible under the Social Security Act and the New York State Constitution [30] for providing every eligible Medicaid recipient with needed SNF and ICF services. See "Statutes," pages 11-12. *Cf. Teitelbaum* v. *Sorenson*, Civ. No. 79-199 PHX WEC (D. Ariz, filed March 16, 1979) (state action in activities of private nursing home based in part on finding that Arizona law makes the duty to provide care for indigent persons a public function). *Contrast Jackson, supra*, 419 U.S. at 353 (Pennsylvania statutory and decisional law did not impose on the *State* the obligation to provide persons with electric service). [31] Further, just as the discriminatory practices in *Burton* allegedly improved its business and benefited the government agency financially (365 U.S. at 724), so do the facility transfers of allegedly inapprop-

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[30] It is settled that under the New York State Constitution the provision of care — including institutionalized care — for old, infirm, and indigent adults who qualify for Medicaid benefits is inherently a public or governmental function. Article 17, §§ 1 and 3, of the New York Constitution. The New York Court of Appeals has made clear the fundamental governmental commitment represented by the constitutional provision at Article 17, § 1. Since the provision of assistance to the needy is "specifically mandated by our Constitution," it is "not a matter of legislative grace," but rather is a "fundamental part of the social contract" and imposes upon the State an "affirmative duty to aid the needy." *Tucker* v. *Toia*, 43 N.Y.2d 1, 7, 8 (1977). *Accord Matter of Lee* v. *Smith*, 43 N.Y.2d 453, 460 (1977).

[31] In performing the State's duty to care for needy persons, the nursing facility provides patients with food, clothing, shelter, and health care upon which they are totally dependent and which they cannot obtain elsewhere. *Cf. Marsh* v. *Alabama*, 326 U.S. 501 (1946); *Teitelbaum, supra* (nursing home is functional equivalent of a company town for the patients, since "all of their needs are met through services provided to them at the facility" and the "overwhelming percentage of the patients are not able to easily leave the facility; many are bedridden.").

riately placed patients benefit the State by satisfying its federally-mandated obligation, no longer dischargeable through the utilization review process, to move inappropriately placed patients. Finally, the State Department of Social Services is responsible for reviewing on the merits the correctness of the nursing facility's discharge or transfer of a Medicaid patient which is the basis for the Department's adjustment of the patient's Medicaid benefits. See "Statutes" page 12. As the Court of Appeals concluded in this case, to the extent that the State fails to perform that inherently governmental function, "[t]he State has, in essence, delegated a decision to increase or reduce a public assistance recipient's benefits to a 'private' party; but such a delegation cannot prevent due process guarantees from attaching." *Yaretsky* v. *Blum*, 629 F.2d 817, 820 (2 Cir. 1980).

In finding state action in the racially discriminatory practices of a private restaurant located in a public parking authority, this Court in *Burton, supra,* observed that "[i]t is irony amounting to grave injustice that in one part of a single building . . . all persons have equal rights, while in another portion, also serving the public, a Negro is a second-class citizen." 365 U.S. at 724. It is similarly "irony amounting to grave injustice" that when a nursing facility seeks to discharge or transfer a Medicaid patient on the basis of a URC physician's decision, the State requires a hearing and the patient's right to disapprove the move, but when that facility seeks to discharge or transfer the same patient based on the decision of the facility director, staff physician, or the attending physician, [32] the State mandates the prompt relocation of the patient without even a hearing. [33]

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[32] In his deposition, Anthony Maddaloni acknowledged that "a physician who may be deriving a substantial part of his salary from treating patients in the facility may be the attending physician for 50 percent of facility and could nonetheless be a utilization review physician for the other patients." Deposition, p. 67. Also Joint Pre-Trial Order (A. 173).

[33] Although patient procedural safeguards are lacking, the potential for abuse and error is substantially greater in facility-initiated discharges or

As in *Burton*, the State and the private entity each constitutes an "integral and, indeed, indispensable" aspect of the other's requirements — the facility's need for patients and financial solvency and profit, and the State's need to fulfill its obligations under the Medicaid program and the New York State Constitution. Under these unique circumstances, the state action requirements of *Burton* are satisfied here. [34]

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transfers than in URC moves. Federal regulations carefully minimize the risks that URC physicians will "do the bidding" of the facility whose patients they review by prohibiting those doctors from any financial interest in the facility or direct responsibility for the care of the patients reviewed. 42 C.F.R. §§ 405.1137(b)(3), 456.306(d). Facility or attending physicians or facility directors who initiate patient transfers outside of the utilization review process are not subject to these safeguards of objectivity and impartiality. Further the facility medical director or facility staff physicians, who are often the patient's attending physicians, have a loyalty to the facility which employs them and a duty to the State to relocate inappropriately placed patients.

[34] Patients who are discharged or transferred from their facilities without the opportunity for a hearing suffer not only the abrupt discontinuance of basic Medicaid services and benefits, but as well summary eviction from their homes, in a context in which the government heavily regulates and subsidizes the homes and narrowly circumscribes the permissible grounds for eviction. Under these circumstances, this case falls squarely within the rationale of Court of Appeals decisions that have found state action in the eviction of low-income tenants by private landlords of housing subsidized under sections 221(d)(3) or 236 of the National Housing Act. *Lopez* v. *Henry Phipps Plaza South, Inc.*, 498 F.2d 937 (2 Cir. 1974); *Joy* v. *Daniels*, 479 F.2d 1236 (1 Cir. 1973); *McQueen* v. *Drucker*, 438 F.2d 781 (1 Cir. 1973).

## POINT III

**A Medicaid Nursing Patient Has A Right Under Federal And State Law To A State Agency Hearing When The State Takes Action To Adjust His Benefit Level Based On A Facility's Patient Discharge Or Transfer To A Lower Level Of Care.**

Federal and state statutes and regulations independently secure the right of a Medicaid patient in an SNF or ICF to notice and a state agency hearing whenever the agency takes "action" to terminate or reduce that person's Medicaid eligibility or benefits on the basis of the facility's discharge of the patient or his transfer to a lower level of care.[35] See "Statutes," page 15. These provisions thus provide non-constitutional grounds for deciding the respondents' rights to a State agency hearing in such cases.[36] *Cf. United States* v. *Rumely*, 345 U.S. 41, 45 (1953); *Crowell* v. *Bensen*, 285 U.S. 22, 62 (1932).

This Court's recent decision in *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980), recognizes that it is the "action" of the State in withdrawing the direct financial benefits

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[35] There is no analytical difference, for purposes of determining patient hearing rights under federal regulations, between the federal requirements of a State agency hearing when the facility transfer is based on a URC determination (to which petitioners unsuccessfully objected, Brief, pages 6 n.*, 34 n.*) and the requirement of such a hearing when the transfer is at the initiative of the facility. The 1976 letter from an Associate Regional Commissioner for Medical Services in Boston, upon which petitioners rely (Brief, page 6 n.*), states only that the statutory right to a hearing is triggered not by the URC or other recommendation to move the patient, but by the State agency's action in discontinuing or reducing Medicaid benefits on the basis of that recommendation.

[36] Respondents asserted and argued in both the District Court and the Court of Appeals the claims that federal and state law require State evidentiary hearings prior to the facility's patient discharge or transfer to a lower level of care. See Joint Pre-Trial Order (A. 157, 163, 166-7); Reply Memorandum in Support of Plaintiffs' Motion for Summary Judgment, R.A. Doc. No. 88, pages 4-8; Brief for Plaintiffs-Appellees in Court of Appeals, dated May 7, 1980, pages 19-21.

provided for Medicaid recipients in nursing homes that entitles the patient to a statutory fair hearing:

> The direct benefits are essentially financial in character; the Government pays for certain medical services and provides procedures to determine whether and how much money should be paid for patient care. The net effect of these direct benefits is to give the patients an opportunity to obtain medical services from providers of their choice that is comparable, if not exactly equal, to the opportunity available to persons who are financially independent. The Government cannot withdraw these direct benefits without giving the patients notice and an opportunity for a hearing on the issue of their eligibility for benefits.

447 U.S. at 786-7. *See also Kane* v. *Perry*, 41 N.Y.2d 1051 (1977), *reversing on opinion at Special Term* (82 Misc.2d 1019) *and dissenting opinion at Appellate Division* (55 A.D. 678).[37]

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[37] The issues at the statutory hearing are summarized earlier in this Brief, page 23 n.23. Federal regulations specifically discuss the hearing which "involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision." 42 C.F.R. § 431.240(b). The State Department of Social Services must ensure that the facility staff physician or facility director or the attending physician "who is responsible" for the decision to move the patient appears at the hearing to defend the decision. 18 N.Y.C.R.R. § 358.9(g). An additional medical assessment of the patient's needs must be obtained if the State Hearing Officer thinks it necessary. 18 N.Y.C.R.R. § 358.16(d).

## CONCLUSION

For the foregoing reasons, this Court should affirm the Judgment below and find that this case presents a justiciable controversy, that there is state action in a nursing facility's transfer of a Medicaid patient to a higher level of care with or without a Utilization Review Committee determination, and that there is state action or alternatively a federal and state law right to a hearing in a nursing facility's discharge or transfer to a lower level of care of a Medicaid patient without a Utilization Review Committee determination.

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